## Crisis Intervention

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## Least is best; do what is needed but not more.

- Unless there is a reason to hospitalize, outpatient management is preferred.
- The needs of the entire social system are critical; (this might include family, police, ER staff, landlord).

## Suggestions for the Crisis Worker

1. Be active. Be willing to be directive and make decisions.
2. Be willing to take calculated risks.
3. Appear calm and in control--whether you are or not.
4. Make sure you have your own support system.
5. Know your goals--clinical, programmatic, or political.

## Initial Approach to the Crisis Situation

1. Listen to the statement about the crisis from the various people involved.
2. Assess risk.
3. Obtain information from collateral sources.
4. Evaluate and maximize degree of cooperativeness from both patient and significant others.

## Initial Questions That Help to Organize the Crisis

1. What is the crisis?
2. Who is involved?
3. Whom is this a crisis for?

## Consider risk of assault

- Start assessment with initial eye contact
  - Need for space
  - Level of agitation
  - Willingness to connect and deescalate
  - Non-verbal sign
- Intoxication
- History of violence or out of control behavior
  - Be specific
- Your supports: do you feel safe?

## How to work with someone who is angry

- What makes you angry?
  - Not being listened to
  - Being threatened
  - Being frustrated
- What makes you less angry
  - Having someone on your side
  - Feeling listened to
  - Have something happen soon

## Understand the Context of the Crisis

1. What are the precipitants or stresses that led to the episode?
2. What is the history of this episode:
3. What other crisis episodes has the person had?
   a. how were they handled?
   b. what are the patients strengths and usual coping mechanisms?
4. What support system does the person have?

## CONSIDER MEDICAL DISEASE:

- If you do not look for it you will not find it.
- The problem with "medical clearance"

## Medical Illness that Can Present as Psychosis

- drug intoxications
- drug withdrawals
- medical emergencies

## Consider medical emergencies that can present as psychiatric illness

1. Hypoglycemia (low blood sugar):
   delirium or coma. palpitations, sweating, anxiety, tremor, vomiting.
2. Diabetic Ketosis or non-ketotic hyperosmolarity (blood sugar so high that it upsets body chemistry)
   delirium with history of diabetes, increased breathing, sweet smell of acetone or breath, dehydration, decreased blood pressure.
3. Wernickes-Korsakoff's syndrome: acute thiamine (vitamin B6) deficiency that can cause rapid brain damage--usually found in alcoholics.
   nystagmus, cerebellar ataxia (person moves as if drunk), peripheral neuropathy, ocular palsies (inability to move both eyes together)

## Consider medical emergencies that can present as psychiatric illness

4. DT's: (delirium tremens) drug withdrawal from alcohol or other sedative hypnotics.
   Frequently missed and can be medically very serious. Elevated blood pressure, pulse and temperature, agitation, visual and tactile hallucinations, and history of alcohol abuse. Onset is usually three to four days after reduction or discontinuation of alcohol.
5. Hypoxia: (low blood oxygen) from pneumonia, MI, COPD, arrythmias, etc.
6. Meningitis: (infection of the covering of the brain)
   stiff neck and fever.

## Consider medical emergencies that can present as psychiatric illness

7. **Subarachnoid Hemorrhage:** (rapid arterial bleeding into the brain) : stiff neck, fluctuating consciousness and headache.
8. **Subdural hematoma: (bleeding, from veins under the outside covering of the brain.** Occurs over hours to weeks or even longer) Symptoms are variable but frequently (not invariably) there is a history of head trauma.
9. **Anticholinergic (atropine) poisoning: from overdose of tricyclics or over-the-counter drugs, or from organophosphate insecticides.**
   - Flushing : "red as a beet"
   - Mouth dry: "dry as a bone"
   - Dilated pupils "blind as a bat"
   - Delirious : "mad as a hatter"

## Differential diagnosis of functional psychosis

- **Is this an acute episode, or part of a chronic picture?**
- **Do not over-diagnose:**
- **Differential diagnosis in the acute situation is useful only as far as it changes immediate treatment**

## Risk Assessment

- **History**
  - **Be specific: what happened when to whom?**
  - **How similar is this to then?**
  - **What helped, or how did it end?**
- **What is the problem the person is trying to solve?**
- **Modifiers: drugs, alcohol, weapons, impulsivity**
- **Who else is involved?**
- **What is the person saying**
- **What are other people saying?**

## Risk Assessment

- **What are the DETAILS of the current situation**
- **What has been happening over the past 2 months or so? How has this incident been developing**
- **What is the person's past history of this or other kind of dangerous behavior. Past suicide attempts or violence? Is this similar, or different? How did the person cope then?**
- **What does the future look like for this person?**

## Suicide Assessment

- **Know demographic risk**
- **Be alert for changes in behavior**
- **Follow the clinical trail**
  - **Ask directly**
  - **Use "gentle assumptions"**
  - **Follow up specifics**
- **BE CONCRETE about what, when, how**

## What is needed now?

- **What additional information is needed?**
- **What does this person need now in terms of:**
  - **a. environment/protection: ?**
  - **b structure**
  - **c. observation**
- **How much and for how long**
- **How can this be provided in the community?**

## Consider whom to get involved and when.

- Family, employers, landlords, etc.
- Important to balance treatment needs with the client's rights to privacy and confidentiality.

**Diamond's Dictum:**

**If you are stuck, enlarge the field!**

## Use Consultants in High Risk Situations

- If you are thinking about calling a consultant, colleague or supervisor, then do so
- Do not feel you have to do it alone
  - Consultation leads to better decisions
  - More creative decisions
  - Better balance or risk and benefit
  - Shared responsibility
- Who do you have to call?
  - Are they really available to you?
  - What are the barriers to calling?

## Consider the use of medication

- When
- What kind
- How much

## Use of Medication with Acutely Psychotic Patient

Consider all of the possible diagnoses.

- Do any of these have contra-indications for any specific medications?
- Do any of these not require medication at all.

## Purpose of medication in crisis situation.

- Specific antipsychotic or antidepressant effects take days to weeks and will not help with the crisis
- Medications can help with behavioral control with very agitated clients
  - Consider the use of nonpharmacological approaches
  - Medication can help the client to get back in control of him or herself.
- Rule out immediate life-threatening conditions

## Medications to help manage a crisis

- Antipsychotic medication
  - Use with Caution in PCP intoxication or organic psychosis (may worsen anticholinergic psychosis).
  - Combination of both antipsychotic medication and benzodiazepine is safe, well tolerated and effective.
- Sedative medications
  - Barbiturates such as Sodium Amytal
  - Short acting benzodiazepines (eg lorazepam) either alone or in combination with haloperidol.

## Medication Use During a Crisis

- Time course depends on route:
  - Intramuscular: peak plasma level 30-60 minutes
  - Oral: peak plasma level 3-6 hours
- Think about long term consequences of medication choice during the crisis
  - How will side effects impact client's willingness to take medication?
  - How is medication presented: to control client, or to help client get back in control of himself?
  - What medication do you think client should be on after this crisis is passed?

## Medication Use During a Crisis (cont)

- Haloperidol 5-10 mg. concentrate or IM every 30-60 minutes. Can be alternated with lorazepam
- Geodon (ziprasidone) injection: 20 mg calms without sedating
- Seroquel (quetiapine): most sedating, can lead to some dizzyness or too much sedation
- Abilify (aripiprazole): more sedating at 30 mg than at 15 mg
- Risperdal (Risperidone) risk of EPS if too big a dose given initially. Start with 1 or 2 mg

## Follow-up Planning Should Begin at the Beginning

What will this persons likely need:

- living situation
- treatment
- daily structure

## What difficulties should one expect following discharge (from a hospital, crisis home, ER)

- not showing up for appointments
  - "unmotivated" and "treatment resistant"
  - What does the client want?
  - Is outreach necessary and available?
- problems in the support system
  - primarily related to client's behavior
  - primarily related to limits of support system
- refusing medications: why is the patient refusing?
  - side effects
  - control issues
  - does medication fit the client's own goals?
  - is client willing to negotiate?
  - what kinds of pressure is available?

## Consider the use of the hospital

- The hospital is a place where treatment can occur, it is not in itself treatment
  - Hospitalize when hospital can provide something that cannot otherwise be provided
  - Do not hospitalize just in response to problem
- What is needed now
  - How can that best be provided
- What are the specific goals for the hospitalization
  - What needs to happen in the hospital
  - How long is this likely to take

## NEED TO FOLLOW THROUGH--

- Do not just "let it go.
- Who is the CRISIS MANAGER
  - make sure that information is collected,
  - plans are made,
  - information is appropriately passed along and updated,
  - patient does not get "lost"in the system.

## After crisis has stabilized

- **Develop a long-term treatment plan**
- **Make sure the patient does not "get lost" in the transition from crisis to ongoing treatment.**
- **Diagnosis is useful for prognosis and development of the ongoing treatment plan.**